Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005012	A. BUILDING: _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH REGIONAL MEDICAL CENTER	5215 HOLY CROSS PKWY MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of two State complaints. Complaint number: IN00159862 Unsubstantiated; lack of sufficient evidence Complaint number: IN00159988 Unsubstantiated; lack of sufficient evidence. Dates of survey: 06/16-17/2015 Facility number: 005012 Saint Joseph Regional Medical Center is in compliance with 410 IAC 15-1.5-5, Medical staff and with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules. QA: cjl 07/13/15	S 000		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE